PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2519

CERTIFICATE OF DEATH

Reg. Dist. No. 6 02504

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 4

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) R.D. 4

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)
SNYDER MILLER ARNOLD	MARCH 12 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	Married	June 17 1891	63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Home painter	self employed	Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
James Arnold	Ida Gamber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	215-32-7467	Lillian Wolfe Arnold R.D. 4 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
420.1 Immediate cause	(a) ACUTE CORONARY OCCLUSION & MYOCARDIAL INFARCTION	5-10 MIN
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) CORONARY ARTERIOSCLEROSIS & ANGINA PECTORIS	10 YRS
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
NONE		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from SEPT., 1952, to MARCH, 1954, that I last saw the deceased alive on MARCH 12 1955, and that death occurred at 2 40 P.M., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE) ADDRESS	DATE SIGNED
William Lewis Stewart, M.D.	59 WEST MAIN ST. WESTMINSTER, MD.	3/12/55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 15, 1955	Trinity Lutheran Cemetery	Smallwood Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-14-55	Hazel Miller	H. Bankard Son	Westminster, Md.

2520

Item 18 Film G160 6-22-55 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 02505

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Sykesville
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Office of Dr. Howard Hall Sykesville, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Sykesville X
STREET ADDRESS (If rural, give location) Church St.

3. NAME OF DECEASED: (Type or Print) (First) RAYMOND (Middle) LORRAINE (Last) ARRINGTON

4. DATE OF DEATH (Month) March (Day) 7 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 12-22-1918

9. AGE last birthday: 36 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Textile Worker

10b. KIND OF BUSINESS OR INDUSTRY: Woolen Mills

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Raymond E. Arrington

14. MOTHER'S MAIDEN NAME: Gladys M. Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W.#II

16. SOCIAL SECURITY NO.: 217-03-2794

17. INFORMANT & ADDRESS: Mrs Gladys M. Arrington. Sykesville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

434.3
Immediate cause (a) Congestive heart failure - etiology undetermined — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐

SIGNATURE Paul F. Ambrose M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED March 8, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 3-10-55

NAME OF CEMETERY OR ~~CREMATORY~~ Springfield

LOCATION (City, town, or county) (State) Sykesville, Carroll, Md.

DATE REC'D BY LOCAL REG. Mar. 9, 1954

REGISTRAR'S SIGNATURE C. Harry Eiler

24. FUNERAL DIRECTOR Luther H. Haight - Sykesville, Md. ADDRESS

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02506

2521 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 1 Y, 13 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury, Maryland 22.12-2.
STREET ADDRESS (If rural give location) unknown

3. NAME OF DECEASED: (First) DELIA (Middle) (Last) BEAUCHAMP
4. DATE OF DEATH: (Month) 3 (Day) 29 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 2/25/67
9. AGE last birthday 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Hammon
14. MOTHER'S MAIDEN NAME: Amelia Rebecca ——— ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

002X IMMEDIATE CAUSE (A) Bilateral Pulmonary Tuberculosis — 1-1/2 yrs.

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Generalized arteriosclerosis — years
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with senile brain disease, with psychotic react. — 3 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/1 , 1954, to 3/29/ , 1955, that I last saw the deceased alive on 3/28/ , 1955, and that death occurred at 9:45AM, from the causes and on the date stated above.

SIGNATURE Edmund Burkham M. D. ADDRESS Sykesville, Maryland DATE SIGNED 3/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
DATE THEREOF 4-1-55
NAME OF CEMETERY OR CREMATORY Delmar Methodist
LOCATION (City, town, or county) (State) DELMAR, DELAWARE

DATE REC'D BY LOCAL REGISTRAR Mar. 29, 1955
REGISTRAR'S SIGNATURE C. Harry Wells
24. FUNERAL DIRECTOR Holloway & Co.
ADDRESS Salisbury, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2522 CERTIFICATE OF DEATH

Reg. Dist. No. 02507

1. PLACE OF DEATH: Henryton
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X Henryton, Maryalnd
LENGTH OF STAY (in this place) 16 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
Edesville
STATE Maryland COUNTY Kent
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall, Maryland 14K-2
STREET ADDRESS (If rural give location) Route #2 ✓

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Henry (Last) Beck

4. DATE OF DEATH: (Month) 3 (Day) 19 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Nov. 15 1900
9. AGE last birthday: 54 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: VARIOUS
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARCELLUS BECK
14. MOTHER'S MAIDEN NAME: ALENDIA HOPKINS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: NO
17. INFORMANT & ADDRESS: Gracee R. Beck---Rte. #2, Rock Hall, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 002X Far Adv. Bilateral Tuberculosis — Interval Between Onset And Death: Sept. 1954
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 10, 19 55, to March 19, 19 55, that I last saw the deceased alive on March 19, 19 55, and that death occurred at 11:15 p.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) T. F. Leonard M. D
ADDRESS Henryton, Maryland
DATE SIGNED 3-19-55

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 3/20/1955
NAME OF CEMETERY OR CREMATORY EDESVILLE CEM
LOCATION (City, town, or county) KENT CO (State) Md

DATE REC'D BY LOCAL REGISTRAR 3-19-55
REGISTRAR'S SIGNATURE Albert R. Smallwood Local Deputy
24. FUNERAL DIRECTOR J. Willis Wells
ADDRESS Chestertown md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02508

2523 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville Md. LENGTH OF STAY (in this place) 8 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield. St. Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Mongomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring Md
STREET ADDRESS (If rural give location) 112 Lexington Dr

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Gertrude (Last) Bogley
4. DATE OF DEATH: (Month) 3 (Day) 22 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	married	Sep. 14 - 1886	68 yrs.	6	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home maker	own home	Bethesda Md	U.S.A.

13. FATHER'S NAME: Benjamin Bean
14. MOTHER'S MAIDEN NAME: Mary Blundon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Unk.	—	Unk. -	Mr. Chester C. Bogley 112 Lexington Dr Silver Spring Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE 422.1 (A) Arteriosclerosis Cardio-vas disease years

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerosis years DUE TO

(C) (260X)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Terminal uremia - Diabetis mellitus days years

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-17-, 1955 to 3-22-, 1955 that I last saw the deceased alive on 3-22-, 1955, and that death occurred at 6.40 P.M., from the causes and on the date stated above.

SIGNATURE Walter H. Sommerfeld M.D. ADDRESS Springfield State Hospital DATE SIGNED 3/27/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/26/55	Rockville Union	Montgomery County Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Mar. 23, 1955	C. Harry Lauer	Warner E. Pumphrey Inc	Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2524

CERTIFICATE OF DEATH

Reg. Dist. No. 12509 / 74

1. PLACE OF DEATH:
COUNTY: CARROLL — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Sykesville
LENGTH OF STAY (in this place): 9 hrs. 15 mins.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Frederick
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Woodsboro 10 X - 2
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) WELDON (Middle) DORSEY (Last) BOHN

4. DATE OF DEATH: (Month) 3 (Day) 31 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 5/27/80

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Frederick County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DANIEL BOHN

14. MOTHER'S MAIDEN NAME: MARY ELIZABETH LEAKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unk.): Unk. (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unk-

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Myocardial infarction — unknown

ANTECEDENT CAUSE (S):
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO (B) Hypertensive cardiovascular disease — unknown
DUE TO (C) Generalized arteriosclerosis — unknown

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic Brain Syndrome associated with cerebral arteriosclerosis, with psyc..otic reaction Unk.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/31, 1955, to 3/31, 1955, that I last saw the deceased alive on 3/31, 1955, and that death occurred at 11:45 AM 9:00 PM.

SIGNATURE: Walter H. Sonnenfeldt, M. D.
ADDRESS: Sykesville, Maryland
DATE SIGNED: 3/31/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 4/3/55
NAME OF CEMETERY OR CREMATORY: Beaver Dam Cem
LOCATION (City, town, or county) (State): Frederick Co Md

DATE REC'D BY LOCAL REGISTRAR: Mar. 31, 1955
REGISTRAR'S SIGNATURE: C. Harry Weed

24. FUNERAL DIRECTOR: D. D. Kaetzel & Son
ADDRESS: Union Bridge

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02510

2525 CERTIFICATE OF DEATH Reg. Dist. No. 80

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN X New Windsor
LENGTH OF STAY (in this place) 8 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS CO

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lynwood Rural X
STREET ADDRESS (If rural give location) Clear Ridge

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) M. (Last) BOWERS
4. DATE OF DEATH: (Month) May (Day) 3 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married	Sept. 30-1870	84 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
housekeeper	at home	Maryland	U.S.

13. FATHER'S NAME: Henry Shulman
14. MOTHER'S MAIDEN NAME: Amelia Sitting

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT'S ADDRESS:
no	no	none	Mrs R Slaugle New Windsor, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

450.0
Immediate cause (a) Arteriosclerosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b)

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-16-, 19 55, to 3-3-, 19 55, that I last saw the deceased alive on 3-3-, 19 55, and that death occurred at 10:30 PM from the causes and on the date stated above.

SIGNATURE J. H. Legg (Degree or title) ADDRESS Union Bridge Md DATE SIGNED 3/4/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 3/6/55 NAME OF CEMETERY OR CREMATORY Winters Cemetery LOCATION (City, town, or county) Carroll County (State) Md

DATE REC'D BY LOCAL REGISTRAR Mar 4 55 REGISTRAR'S SIGNATURE Orson S Bennett 24. FUNERAL DIRECTOR D D Hartzler & Sons ADDRESS New Windsor, Md.

Mar 5-55

VS. A15

02511

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2526

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 6months 10 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ~~Baltimore~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~B~~altimore 3 Vol-4
STREET ADDRESS (If rural give location) 2500 St.Paul's Str.

3. NAME OF DECEASED: (Type or Print) (First) Elsie (Middle) (Last) Bruder

4. DATE OF DEATH: (Month) 3 (Day) 26 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed

8. DATE OF BIRTH: 1880 Jan.26

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper

10B. KIND OF BUSINESS OR INDUSTRY: rooming house

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Silas Jenkins

14. MOTHER'S MAIDEN NAME: Annabelle Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Melva Freter, 3507 Meadowside Road, Balto 7,

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

170X
IMMEDIATE CAUSE (A) Generalized malignancy — months
ANTECEDENT CAUSE (B) DUE TO Malignancy of the breast with metastases to skull and bones — 2 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypostatic bronchopneumonia — 12 days

19A. DATE OF OPERATION: 3-3-1955
19B. MAJOR FINDINGS OF OPERATION: Mass at the anterior chest wall
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-20, 1954 to 3-25, 1955, that I last saw the deceased alive on 3-25-55, and that death occurred at 12.50 M, from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus — ADDRESS M.D. Springfield St.Hospital — DATE SIGNED March 26,1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
DATE THEREOF: 3-29-1955
NAME OF CEMETERY OR CREMATORY: Ebenezer
LOCATION (City, town, or county) (State): Carroll Co.,Maryland

DATE REC'D BY LOCAL REGISTRAR: Mar. 22,1955
REGISTRAR'S SIGNATURE: C. Harry Klee

24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, Maryland — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02512

2527 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS OD

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville X
STREET ADDRESS (If rural give location) Eldersburg 1

3. NAME OF DECEASED. (Type or Print) (First) Charles (Middle) William (Last) Brunsman

4. DATE OF DEATH (Month) March (Day) 26 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: 1-29-1888

9. AGE last birthday 67 yrs

IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph L. Brunsman

14. MOTHER'S MAIDEN NAME: Mary O'Donnell

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) Unk - (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk -

17. INFORMANT & ADDRESS: Mrs Alice Brunsman - Sykesville Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

20IX

IMMEDIATE CAUSE (A) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH 18 mo

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954 to 3/26/, 1955, that I last saw the deceased alive on 3/26/, 1955, and that death occurred at 9:35 P.M., from the causes and on the date stated above.

SIGNATURE Von E. Martin M.D. ADDRESS Randallstown Md DATE SIGNED 3/27/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 3-29-55 | NAME OF CEMETERY OR CREMATORY Holy Family | LOCATION (City, town, or county) (State) Hanisonville, Balto. Co., Md.

DATE REC'D. BY LOCAL REGISTRAR 3/21/55 | REGISTRAR'S SIGNATURE C. Harry Feer Jr | 24. FUNERAL DIRECTOR. ADDRESS Luther N. Haight - Sykesville, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02513

2528

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1 PLACE OF DEATH

COUNTY Carroll — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville

LENGTH OF STAY (in this place) 1 year

HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Frederick

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick

STREET ADDRESS (If rural give location) 230 W. 5th Street

3. NAME OF DECEASED: (First) Harry (Middle) Ely (Last) CONNER

4. DATE OF DEATH (Month) March (Day) 20 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: February 12, 1883

9. AGE last birthday IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —: 72 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Peter Conner

14. MOTHER'S MAIDEN NAME: Elizabeth Michael

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

931 X

IMMEDIATE CAUSE (A) Embolus of pulmonary artery — minutes

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cerebrovascular accident — 2 weeks

DUE TO

(C) —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. General Paresis — more than 1 yr.

19A. OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 28, 1954, to Mar. 20 19 55 that I last saw the deceased alive on March 20, 1955, and that death occurred at 1:00PM, from the causes and on the date stated above.

SIGNATURE Martin Gross M D — ADDRESS Martin Gross, M. D Sykesville, Maryland — DATE SIGNED 3/21/55

23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF March 23,1955 — NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery — LOCATION (City, town, or county) (State) Frederick, Maryland

DATE REC'D BY LOCAL REGISTRAR 21 March 1955 — REGISTRAR'S SIGNATURE C. Henry Zeller

24. FUNERAL DIRECTOR — ADDRESS M. R. Etchison & Son, Frederick, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02514

2529 **CERTIFICATE OF DEATH** Reg. Dist. No. 7.0

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Keymar
LENGTH OF STAY (in this place) 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keymar X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) Elmer (Last) Deberry

4. DATE OF DEATH: (Month) March (Day) 31, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: October 23, 1886

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Deberry

14. MOTHER'S MAIDEN NAME: Sophia Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Mrs. George Deberry, Keymar, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

177X IMMEDIATE CAUSE (A) Carcinoma Prostate — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1954, to April, 1955 that I last saw the deceased alive on 3-31, 1955, and that death occurred at 10 PM, from the causes and on the date stated above.

SIGNATURE J. H. Legg, M. D. ADDRESS Union Bridge, Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF April 3, 1955 | NAME OF CEMETERY OR CREMATORY Keysville Cemetery | LOCATION (City, town, or county) (State) Keysville, Carroll, Maryland

DATE REC'D BY LOCAL REGISTRAR April 4, 1955 | REGISTRAR'S SIGNATURE Ethel M. Mehring

24. FUNERAL DIRECTOR ADDRESS C.O. Fuss & Son, Taneytown, Maryland

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

02515

MARYLAND 2530

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. ~~33~~ 76

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. Baltimore COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Owings Mills
STREET ADDRESS (If rural, give location) Reisterstown Road

3. NAME OF DECEASED (Type or Print): (First) Harriet (Middle) Elizabeth (Last) Disney

4. DATE OF DEATH (Month) (Day) (Year): March 30, 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 19, 1866

9. AGE last birthday: 89 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore County

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George W. Bower

14. MOTHER'S MAIDEN NAME: Isabelle Peck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: David Disney, Owings Mills, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153 X Immediate cause (a) Carcinoma of colon — Interval between onset and death: 18 mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cachexia & metastasis

(c) hypertension & arteriosclerosis 3 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-30, 19..., to 3-30-55, 19..., that I last saw the deceased alive on 3-29-55, 19..., and that death occurred at 10:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Allen L. Lafell M.D. — ADDRESS Reisterstown Md. — DATE SIGNED 3-31-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: April 2/55 — NAME OF CEMETERY OR CREMATORY: Pleasant Hill — LOCATION (City, town, or county) (State): Owings Mills, Md.

DATE REC'D BY LOCAL REG. 4-1-55 — REGISTRAR'S SIGNATURE Harriett Miller B

24. FUNERAL DIRECTOR — ADDRESS: J.F. Eline & Sons, Reisterstown, Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02516

2531

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 3days 5 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible] Baltimore 11, Md.
STREET ADDRESS (If rural give location) 3703 Elm Street

3. NAME OF DECEASED: (Type or Print) (First) Herman (Middle) Hazel (Last) Fisher

4. DATE OF DEATH: (Month) 3 (Day) 12 (Year) 1955.

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: 10- 15- 1893

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk-

10B. KIND OF BUSINESS OR INDUSTRY: oil business

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christopher Fisher

14. MOTHER'S MAIDEN NAME: Laura Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Lelia Fisher, 3703 Elm Str. Baltimore 11.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1457

IMMEDIATE CAUSE (A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Rheumatic Heart Disease — yeras

DUE TO

(C) Arteriosclerotic cardiovascular disease — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Left Hemiplegia, Chronic brain syndrome with psychotic reactions — yeras

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-10- , 1955, to 3- 12- , 1955, that I last saw the deceased alive on 3- 11- , 1955, and that death occurred at 3-12: AM, from the causes and on the date stated above.

SIGNATURE Edmund Leuthaus M.D. ADDRESS Springfield State Hospital DATE SIGNED 3-12-1955.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 3-15-55 — NAME OF CEMETERY OR CREMATORY Woodlawn — LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR Mar. 12, 1956 — REGISTRAR'S SIGNATURE C. Harry Thies

24. FUNERAL DIRECTOR H. H. Burger — ADDRESS 3631 Falls Rd. Balto.

02517

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2532

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 9/16/52
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) Stoner Avenue 1

3. NAME OF DECEASED: (Type or Print) (First) Wesley (Middle) Milton (Last) GEIMAN

4. DATE OF DEATH (Month) March (Day) 29 (Year) 1955

5. SEX male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widower

8. DATE OF BIRTH. ~~Oct 28, 1876~~ ? 1875

9. AGE last birthday IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. — 79 ? yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10B. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Westminster, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Abraham Geiman

14. MOTHER'S MAIDEN NAME: ~~unknown~~ Catherine Petry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.1

(A) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: days ?

DUE TO

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B) Bronchopneumonia — 10 days

DUE TO

(C) ---

SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile brain disease, psychotic reaction — 3 yrs.

19A. DATE OF OPERATION: ---

19B. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ---

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Nov. 25, 1952 to Mar. 29, 1955, that I last saw the deceased alive on Mar. 29, 1955, and that death occurred at 6:40PM, from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. — ADDRESS Martin Gross M.D. Sykesville, Maryland — DATE SIGNED 3/30/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 4-2-55 — NAME OF CEMETERY OR CREMATORY Meadow Branch — LOCATION (City, town, or county) (State) Westminster, Md.

DATE REC'D BY LOCAL REGISTRAR Mar. 30 1955 — REGISTRAR'S SIGNATURE C. Tracy Elmer — 24. FUNERAL DIRECTOR & ADDRESS W. Benton Hon - Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02518

2533 CERTIFICATE OF DEATH Reg. Dist. No. 27

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 6month21days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (14) 15 X-2
STREET ADDRESS (If rural give location) 6210 Verne Street ✓

3. NAME OF DECEASED: (Type or Print) (First) ROSE (Middle) (Last) HALE
4. DATE OF DEATH: (Month) March (Day) 3 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 10-11-75
9. AGE last birthday 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bosselle
14. MOTHER'S MAIDEN NAME: Helen Cichem

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4424 IMMEDIATE CAUSE (A) Cardio-vascular-renal disease — INTERVAL BETWEEN ONSET AND DEATH: years.

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Arteriosclerosis — years
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain disease, 1yr. 3mo. with psychotic reaction.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-?? , 1955, to 3-3 , 1955, that I last saw the deceased alive on 3-2 , 1955, and that death occurred at 3:25A M, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 3-3-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 3-5-55
NAME OF CEMETERY OR CREMATORY Pinewood Cem.
LOCATION (City, town, or county) Essex Co. (State) Mass

DATE REC'D BY LOCAL REGISTRAR Mar. 4, 1955
REGISTRAR'S SIGNATURE C. [illegible] Zdear
24. FUNERAL DIRECTOR Roberts. Pumphrey ADDRESS Bethesda, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02519

2534

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Sykesville
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
STREET ADDRESS (If rural give location) Mannotteville Road

3. NAME OF DECEASED: (Type or Print) (First) Jennie (Middle) Virginia (Last) Hammond

4. DATE OF DEATH: (Month) March (Day) 23 (Year) 1955

5. SEX: F. | 6. COLOR OR RACE: Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: May - 1887 | 9. AGE last birthday 67 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: Home | 11. BIRTHPLACE (State or foreign country): Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Scott | 14. MOTHER'S MAIDEN NAME: Unknown

15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. none | 17. INFORMANT & ADDRESS: Etta Myers. Sykesville, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

ANTECEDENT CAUSE (B) Hypertension — 15 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

(C) Arteriosclerotic heart disease — 10 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Uremia — 6 months

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. ..., 19 55 to 3-23, 19 55, that I last saw the deceased alive on 3-23, 19 55, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

SIGNATURE Howard E. Doll M.D. | ADDRESS Sykesville Md | DATE SIGNED 3-24-55

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial | DATE THEREOF 3-26-55 | NAME OF CEMETERY OR CREMATORY Daisy | LOCATION (City, town, or county) (State) Howard Co., Md.

DATE REC'D BY LOCAL REGISTRAR Mar. 24, 1955 | REGISTRAR'S SIGNATURE C. Harry Weer | 24. FUNERAL DIRECTOR Walter H. Haight | ADDRESS Sykesville, Md.

02520

MARYLAND 2535

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (In this place) 9yrs. 5mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3Y01-4
STREET ADDRESS (If rural, give location) 1616 Shady Side Road

3. NAME OF DECEASED (Type or Print): (First) Lucille (Middle) Amelia (Last) Herzog

4. DATE OF DEATH: (Month) Mar. (Day) 10 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 10-27-1882

9. AGE Last birthday: 72 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Doerner

14. MOTHER'S MAIDEN NAME: Anna Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval between onset and death: 1½ d

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c) Psychosis & cerebral arterio sclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ——— 19b. MAJOR FINDINGS OF OPERATION: ———

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ——— PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ——— (CITY OR TOWN) ——— (COUNTY) ——— (STATE) ———

TIME OF INJURY (Month) ——— (Day) ——— (Year) ——— (Hour) ——— m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? ———

22. I hereby certify that I attended the deceased from 5-23- 19 46, to 3-10, 19 55, that I last saw the deceased alive on 3-10, 19 55, and that death occurred at 6 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Edward Leuthauer ADDRESS Springfield Hospital, Sykesville DATE SIGNED 3-10-55

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE 3-14-55 NAME OF CEMETERY OR CREMATORY Holy Redeemer LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. Mar. 11, 1955 REGISTRAR'S SIGNATURE C. Henry Ulrich

24. FUNERAL DIRECTOR Wm Cook Sr. ADDRESS 1217 W Fayette St. Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2536

Item 3. film 6181-5/3/57 L

CERTIFICATE OF DEATH

02521

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY: CARROLL — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Sykesville
LENGTH OF STAY (in this place): 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BALTIMORE CITY
STREET ADDRESS (If rural give location): 1532 Sheffield Road

3. NAME OF DECEASED: (First) LOCH (Middle) ~~ELLEN~~ Weems (Last) HUMPHREYS, Sr.

4. DATE OF DEATH: (Month) 3 (Day) 21 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: 11/2/74

9. AGE last birthday: 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: U. S. Gov't.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joshua Humphreys

14. MOTHER'S MAIDEN NAME: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-01-5101

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
(IMMEDIATE CAUSE) 290.2	(A) Macrocytic anemia	over 1 year
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO	
	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic brain syndrome associated with senile brain disease, with psychotic react. unk.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/6, 1955, to 3/21, 1955, that I last saw the deceased alive on 3/21, 1955, and that death occurred at 8:10 A M, from the causes and on the date stated above.

SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS: Sykesville, Maryland — DATE SIGNED: 3/21/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — **DATE THEREOF:** 3/23/55 — **NAME OF CEMETERY OR CREMATORY:** Loudon Park Cem. — **LOCATION (City, town, or county) (State):** Balto., Md.

DATE REC'D BY LOCAL REGISTRAR: 3/21/55 — **REGISTRAR'S SIGNATURE:** A. A. Heduck — **24. FUNERAL DIRECTOR:** Wm. J. Tickner & Sons — **ADDRESS:** Balto 17 Md

2537

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 02522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH: [redacted] COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN X Linwood
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Montgomery
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN R. Germantown 15 X 2.
STREET ADDRESS (If rural, give location) R. Germantown

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) FREDRICK STALEY (Last) JACOBS.
4. DATE OF DEATH (Month) March (Day) 12 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	April 22, 1903	51 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Plaster Contractor	Own	Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Frederick C. Jacobs	May Virginia Phelps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	No	219-12-2450	Mrs. Lucille K. Jacobs, Germantown R.D.#1, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T. Church M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED May 12, 1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar. 15, 1955	Rocky Hill Cemetery	Frederick County, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
March 14, 1955	Lucie T. Phelps	M. R. Etchison & Son, Frederick, Maryland

Reg. Dist. 81

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2538

CERTIFICATE OF DEATH

02523

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Henryton
LENGTH OF STAY (in this place) 3yrs. 9mos. 23days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 23 HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 91 Calvert Street

3. NAME OF DECEASED: (Type or Print) (First) CLARENCE (Middle) (Last) JOHNSON

4. DATE OF DEATH: (Month) 3 (Day) 27 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 6-26-1907

9. AGE last birthday: 47 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: Truck Driver

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Horace Johnson

14. MOTHER'S MAIDEN NAME: Frances Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-14-0002

17. INFORMANT & ADDRESS: Clarence Johnson (deceased)

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of the esophagus with metastasis — Interval Between Onset And Death:

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Far advanced bilateral pulmonary tuberculosis — July, 1951

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 5, 19 51, to Mar. 27, 19 55, that I last saw the deceased alive on Mar. 27, 19 55, and that death occurred at 6:20 a.m., from the causes and on the date stated above.

SIGNATURE T. F. Vestal — (Degree or title) M.D — ADDRESS Henryton, Maryland — DATE SIGNED 3-27-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 3/30/55 — NAME OF CEMETERY OR CREMATORY Green Hill Cemetery — LOCATION (City, town, or county) Annapolis Md. (State)

DATE REC'D BY LOCAL REGISTRAR 3/27/55 — REGISTRAR'S SIGNATURE Albert R. Swanborn Local Deputy

24. FUNERAL DIRECTOR & Mrs C. L. Shirk — ADDRESS 137 W. St Annapolis Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2539

CERTIFICATE OF DEATH

Reg. Dist. No. 02524 / 7A

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 10yr2mo24days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 822 E. Fort Avenue

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) F. (Last) JOHNSON, JR.

4. DATE OF DEATH: (Month) March (Day) 2 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 11-23-02

9. AGE last birthday: 52 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William F. Johnson

14. MOTHER'S MAIDEN NAME: Tillie Kern

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 x 0.1

IMMEDIATE CAUSE (A) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B) Coronary Arteriosclerosis — Unknown

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with mental deficiency — Many Years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-30, 1954, to 3-2, 1955, that I last saw the deceased alive on 3-2-, 1955, and that death occurred at 10:55 AM, from the causes and on the date stated above.

SIGNATURE Walther H. Sommerfeldt M. D. — ADDRESS Springfield State Hospital — DATE SIGNED 3-2-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) B — DATE THEREOF 3/5/55 — NAME OF CEMETERY OR CREMATORY Loudon Park — LOCATION (City, town, or county) (State) Baltimore

DATE REC'D BY LOCAL REGISTRAR 3-5-55 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS James L. McCully - 130 E. Fort Ave.

02525

MARYLAND 2540

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Carroll - Md. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9. Pollen Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 Rural-4
STREET ADDRESS (If rural, give location) 16 Forest Ave. 4217 Euclid Ave

3. NAME OF DECEASED (Type or Print): (First) CLARA (Middle) J. (Last) KEEN
4. DATE OF DEATH: (Month) (Day) (Year) MARCH 24 1955
5. SEX: FEMALE
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug 20, 1869
9. AGE last birthday: 85 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: HIRAM ENOS
14. MOTHER'S MAIDEN NAME: MARY ANN BOYER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) V (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Mrs. Myrtle Roth 4217 Euclid Ave. (29)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause (a) Cardiac arrest — Cardiac failure,
Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis, arthritis, myocardial
(c) infarction

INTERVAL BETWEEN ONSET AND DEATH
(a) 14 March 55
(b) 24 March 55

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) Sykesville (COUNTY) Carroll (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED ~~While at Work~~ ☐ ~~Not While~~ At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 14 March, 19 55, to 24 March, 19 55, that I last saw the deceased alive on 24 March, 19 55, and that death occurred at 4:10 P m., from the causes and on the date stated above.
SIGNATURE (Degree or title) Howard E. Hall MD ADDRESS Sykesville, Md DATE SIGNED 24 March 55

23. BURIAL, CREMATION OR REMOVAL (Specify) Burial DATE March 26, 1955 NAME OF CEMETERY OR CREMATORY Western Cem. LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REG. March 26, 1955 REGISTRAR'S SIGNATURE R.W
24. FUNERAL DIRECTOR George Thomas Schmuck ADDRESS 3512 Frederick Ave.

MARGIN RESERVED FOR BINDING

I

Former residence from House In Pines, 16 Fusting Ave., by phone. 3-28-55 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02526

2516 CERTIFICATE OF DEATH Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 Locust Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
STREET ADDRESS (If rural give location) 17 Locust Street

3. NAME OF DECEASED: (Type or Print) (First) Lona (Middle) May (Last) Kiler
4. DATE OF DEATH: (Month) March (Day) 21 (Year) 19 55
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Marries
8. DATE OF BIRTH: May 27, 1877
9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Frederick County, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Issac Nusbaum
14. MOTHER'S MAIDEN NAME: Manzella Repp
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) - - - -
16. SOCIAL SECURITY No.: ---- - --
17. INFORMANT & ADDRESS: Theo. G. Kiler Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 450.0 (a) Arteriosclerosis & Coronary DUE TO — Interval Between Onset And Death: 2 years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) heart failure DUE TO — 2 weeks

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept ,1948, to Mar ..., 1955, that I last saw the deceased alive on Mar 21, 1955, and that death occurred at 7:35PM, from the causes and on the date stated above.

SIGNATURE Julius Olejko (Degree or title) M. D. ADDRESS Westminster Md DATE SIGNED 3/22/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Mar.24,1955 NAME OF CEMETERY OR CREMATORY Krider's Cemetery LOCATION (City, town, or county) (State) near Westminster, Md.

DATE REC'D BY LOCAL REGISTRAR 3-24-55 REGISTRAR'S SIGNATURE Hamil Miller

24. FUNERAL DIRECTOR John R. Byers ADDRESS Westminster, Md.

VS. A15

MARYLAND 2541

STATE DEPARTMENT OF HEALTH 02527

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH- COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (In this place): 33 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 3V01-4
STREET ADDRESS (If rural, give location): Not known

3. NAME OF DECEASED (Type or Print): (First) Carrie (Middle) (Last) Klaus
4. DATE OF DEATH: (Month) March (Day) 16, (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Not known
9. AGE last birthday: 73 ? yrs. — If under 1 year: Months / Days — If under 24 hr: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Work -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Angus E. Klaus
14. MOTHER'S MAIDEN NAME: Louise Croble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: -Unk-
17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
331X Immediate cause	(a).	Cerebrovascular Accident	2-3 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b).	Generalized arteriosclerosis	years
	(c).		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, paranoid — 33 years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-4, 19 21., to 3-16, 1955., that I last saw the deceased alive on 3-16, 1955., and that death occurred at 4:45 P.m., from the causes and on the date stated above.

SIGNATURE: Gertrud Sonnenfeld M.D. (Degree or title) — ADDRESS: Springfield State Hospital, Sykesville Md. — DATE SIGNED: 3/16/55

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE: Mar 23, 1955 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State): Community Medical [illegible]

DATE REC'D BY LOCAL REG.: Mar 23, 1955 — REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR: Wm. S. J. Hennekey — ADDRESS: 578 W. Fayette St

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2542

CERTIFICATE OF DEATH

02528

Reg. Dist. No. 7H

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 10months16days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington 15 X-2
STREET ADDRESS (If rural give location) 9632 Old Spring Road ✓

3. NAME OF DECEASED: (First) EMMA (Middle) (Last) LIPSCOMB
4. DATE OF DEATH: (Month) March (Day) 2 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 3-1-1886
9. AGE last birthday: 69 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Brown
14. MOTHER'S MAIDEN NAME: Emma Louise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. Unk-
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
331X IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
ANTECEDENT CAUSE (S) DUE TO (B) Cerebral arteriosclerosis — more than one year
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic 11 month reaction.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-9, 1954 to 3-2, 1955 that I last saw the deceased alive on 3-2, 1955, and that death occurred at 11:05 P M, from the causes and on the date stated above.
SIGNATURE Walter H. Townsend M.D. ADDRESS Springfield State Hospital DATE SIGNED 3/3/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 3-5-55
NAME OF CEMETERY OR CREMATORY Cedar Hill Cem
LOCATION (City, town, or county) Prince Geo. County, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Mar 3, 1955
REGISTRAR'S SIGNATURE C. Thomas [illegible]
24. FUNERAL DIRECTOR S.H. Hines Co
ADDRESS 2901-14th St. N.W. Wash. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02529

2543

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll Co — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
LENGTH OF STAY (in this place) all his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 319 Stoner Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
STREET ADDRESS (If rural give location) 319 Stoner Ave.

3. NAME OF DECEASED: (Type or Print) (First) JOSEPH (Middle) ALLAN (Last) LONG

4. DATE OF DEATH: (Month) March (Day) 16 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Feb. 1, 1903

9. AGE last birthday: 52 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction Co.

11. BIRTHPLACE (State or foreign country): West Minster Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Long

14. MOTHER'S MAIDEN NAME: Gertrude Baubert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-07-3831

17. INFORMANT & ADDRESS: Mrs. Jos. A. Long, Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 4 hours

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Vascular disease — about 3 years
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None (Nervousness) — 20 years

19a. DATE OF OPERATION: none — **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) no — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from about Apr. 15, 1946, to 3-14, 1955, that I last saw the deceased alive on 3-16, 1955, and that death occurred at 9 15 A.M., from the causes and on the date stated above.

SIGNATURE J. L. Billingslea — (Degree or title) M.D. — ADDRESS Westminster, Md — DATE SIGNED 3-16-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF March 19, 55 — NAME OF CEMETERY OR CREMATORY Kruders Cemetery — LOCATION (City, town, or county) (State) Rural Westminster Md.

DATE REC'D BY LOCAL REGISTRAR 3-17-55 — REGISTRAR'S SIGNATURE Harriet F. Walter

24. FUNERAL DIRECTOR J. E. Myers Jr. — ADDRESS Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02530

2544

CERTIFICATE OF DEATH

Reg. Dist. No. 24

Item 22, Film 179 3-21-55 ct

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville, | LENGTH OF STAY (in this place) 7 m 10 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3
STREET ADDRESS (If rural give location) 2423- 32 nd Street, S.E.

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Leona (Last) Mumma

4. DATE OF DEATH: (Month) 3 (Day) 12 (Year) 1955.

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed | 8. DATE OF BIRTH. 6-6-1884 | 9. AGE last birthday 70 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H/wife | 10B. KIND OF BUSINESS OR INDUSTRY: None | 11. BIRTHPLACE (State or foreign country): U.S.A. Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Brewer | 14. MOTHER'S MAIDEN NAME: Carrie Eyerly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) unknown | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT & ADDRESS: Ross Brewer , 2423-32nd Str.SE, Washington D.C.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 IMMEDIATE CAUSE	(A) Uremia terminal	30 hours
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Arteriosclerotic cardiovascular disease	years
	DUE TO	
	(C) Bronchopneumonia	7 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Involutional Psychosis	27 years

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-10- , 1955, to 3-12 19 55 that I last saw the deceased alive on 3-11- , 1955 , and that death occurred at 2:30 AM, from the c[illegible]s and on the date stated above.

SIGNATURE Edmund Leathers M. D. | ADDRESS Springfield State Hopsital | DATE SIGNED 3-12-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF 3/15/55 | NAME OF CEMETERY OR CREMATORY St Paul's Cemetery | LOCATION (City, town, or county) (State) Near Hagerstown Md

DATE REC'D BY LOCAL REGISTRAR Mar. 12, 1955 | REGISTRAR'S SIGNATURE C. Harry Mills | 24. FUNERAL DIRECTOR ADDRESS H.K. Hoffman Hagerstown Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02532

2545

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Henryton
LENGTH OF STAY (in this place) 1yr. 7 mths.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Ca.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barclay
STREET ADDRESS (If rural give location) 7X-2

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) (Last) MURRAY

4. DATE OF DEATH: (Month) AR. (Day) 3 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 4-6-81

9. AGE last birthday: IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min. — 73 yrs.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Barclay, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph H. Murray

14. MOTHER'S MAIDEN NAME: Carolina Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X

Immediate cause (a) Far. adv. bilat. pul. cavitary tbc. DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 4yrs.8mths

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-8, 19 53, to 3-3, 19 55, that I last saw the deceased alive on 3-3, 19 55, and that death occurred at 9:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Plestal M.D. ADDRESS Henryton, Maryland DATE SIGNED 3-3-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 3/6/55 — NAME OF CEMETERY OR CREMATORY Barclay Cem. — LOCATION (City, town, or county) Barclay (State) Md.

DATE REC'D BY LOCAL REGISTRAR 3-3-55 — REGISTRAR'S SIGNATURE Albert R. Sarandrea — 24. FUNERAL DIRECTOR Edgar L. Lane — ADDRESS Church Hill Md.

Deputy Local

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02531

2546

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
LENGTH OF STAY (in this place) 52 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 Gist Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster
STREET ADDRESS (If rural give location) 21 Gist Road

3. NAME OF DECEASED: (Type or Print) (First) SALLIE (Middle) GRACE (Last) MYERLY

4. DATE OF DEATH: (Month) March (Day) 18 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept 5, 1869

9. AGE last birthday: 86 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Home-wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Fred. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Whitmore

14. MOTHER'S MAIDEN NAME: Rebecca Staubaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. W. Louise Myerly, Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1
Immediate cause (a) Acute Heart Failure — Interval Between Onset And Death: 1 hr.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Pulmonary Edema — 2 hrs

DUE TO

(c) Arterio Sclerotic Cardiovascular Renal — years.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 25, 1953, to Mar. 18, 1955, that I last saw the deceased alive on Mar. 18, 1955, and that death occurred at 6:50 AM., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

G. Allen Middleton M.D. Westminster Md 3/19/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF March 21/55

NAME OF CEMETERY OR CREMATORY Meadow Branch

LOCATION (City, town, or county) (State) Rural, Westminster, Md.

DATE REC'D BY LOCAL REGISTRAR 3-19-55

REGISTRAR'S SIGNATURE Hannah Miller

24. FUNERAL DIRECTOR J. S. Myers Jr. ADDRESS Westminster, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

02533

2547

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7 D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DeTour RURAL — LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DeTour RURAL
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Mary (Last) Myers

4. DATE OF DEATH: (Month) March (Day) 3 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: 1-20-1888

9. AGE last birthday: 67 yrs. — If under 1 year: Months — Days 13 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Deberry

14. MOTHER'S MAIDEN NAME: Sophia Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Raymond Myers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

17 4 x

Immediate cause (a) Carcinoma - Uterus — Interval Between Onset and Death: 4 yrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-9-, 1953, to 3-3-, 1953, that I last saw the deceased alive on 3-3-, 1953, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. A Kegg md — ADDRESS Union Bridge — DATE SIGNED 3-4-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: March 6, 53 — NAME OF CEMETERY OR CREMATORY: Keysville Cem — LOCATION (City, town, or county) (State): Keysville Md.

DATE REC'D BY LOCAL REG. — REGISTRAR'S SIGNATURE: Ethel M Mehring

24. FUNERAL DIRECTOR: M.L. Creager & Son — ADDRESS: Thurmont

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02534

2548

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY (If outside corporate limits, write RURAL) OR TOWN X Sykesville; LENGTH OF STAY (In this place) 4 mos 20 da; HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Baltimore; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4; STREET ADDRESS (If rural give location) 2520 E. Hoffman St.

3. NAME OF DECEASED: (Type or Print) (First) Catherine (Middle) Brandau (Last) Riemeyer

4. DATE OF DEATH: (Month) Mar (Day) 18 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED: (Write) Married

8. DATE OF BIRTH: Nov. 3-1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months 4 Days 24; IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Valentine Brandau

14. MOTHER'S MAIDEN NAME: Caroline Brandau Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: 2520 E Hoffman St Thorton Riemeyer Balto

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S) DUE TO (B) Gen Arterio Sclerosis — 6 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 10, 1955, to Mar 18 1955 that I last saw the deceased alive on Mar 18, 1955, and that death occurred at 5-10 P M, from the causes and on the date stated above.

SIGNATURE M.D. W W Martin M D — ADDRESS Sykesville Md — DATE SIGNED Mar 18 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 3-22-55 — NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery — LOCATION (City, town, or county) (State): Balto Md.

DATE REC'D BY LOCAL REGISTRAR: 3 - 5[illegible] — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: John C. Miller Inc. — ADDRESS: 2431 E. Oliver St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02535

2549

CERTIFICATE OF DEATH

Reg. Dist. No. ....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 39y.11m.17d.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) THOMAS (Middle) P (Last) RAFTERY

4. DATE OF DEATH: (Month) March (Day) 24 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: January 9, 1870

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stevedore

10B. KIND OF BUSINESS OR INDUSTRY: Shipping

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Raftery

14. MOTHER'S MAIDEN NAME: Mary Flanagan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.1

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

ANTECEDENT CAUSE (B):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (307X)

(B) Arteriosclerotic cardiovascular disease — Years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic alcoholic hallucinosis. — 40

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16, 1955, to 3-24, 1955, that I last saw the deceased alive on 3-24, 1955, and that death occurred at 8:25 AM, from the causes and on the date stated above.

SIGNATURE W. H. Sonnenfeldt. ADDRESS M. O Springfield State Hospital DATE SIGNED 3-24-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF 3-28-55 | NAME OF CEMETERY OR CREMATORY Mt. Cathedral | LOCATION (City, town, or county) (State) Balto MD

DATE REC'D BY LOCAL REGISTRAR 3/25/55 | REGISTRAR'S SIGNATURE U. W. Hedrick | 24. FUNERAL DIRECTOR Charles H. Crown & Son | ADDRESS

02536

MARYLAND 2550

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item 3, FilmG180 4-26-55 et

1. PLACE OF DEATH — COUNTY: Carroll — Sykesville — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural
LENGTH OF STAY (in this place): 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 13 3Y01-4
STREET ADDRESS (If rural, give location): 1826 Wilkins Ave

3. NAME OF DECEASED (Type or Print): (First) Nannie (Middle) Alverta (Last) Ridgley

4. DATE OF DEATH: (Month) 3 (Day) 27 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 4/28/1886

9. AGE last birthday: 68 yrs.
If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Thomas

14. MOTHER'S MAIDEN NAME: Alberta ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY No.: Unk

17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 331X Cerebral Hemorrhage — Interval Between Onset and Death: minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Cerebral Arteriosclerosis — years
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
C B S. due to cerebral arteriosclerosis — years

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/22, 1955, to 3/27, 1955, that I last saw the deceased alive on 3/27, 1955, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Gertrude M. Goss, M.D. ADDRESS: Sykesville, Md. DATE SIGNED: 3/27/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE: 3-30-1955
NAME OF CEMETERY OR CREMATORY: Springfield
LOCATION (City, town, or county) (State): Sykesville, Md.

DATE REC'D BY LOCAL REG.: Mar. 28, 1955
REGISTRAR'S SIGNATURE: C. Henry Zinn

24. FUNERAL DIRECTOR — ADDRESS: C.M.Waltz, Winfield, Maryland

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02537

2551

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 1month13days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring 21 x - 2
STREET ADDRESS (If rural give location) Route # 1

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) ELIZABETH (Last) ROBINSON

4. DATE OF DEATH: (Month) March (Day) 18 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5-4-07
9. AGE last birthday: 47 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James A. Lucas, dec.
14. MOTHER'S MAIDEN NAME: Mary F. ? dec.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
023X IMMEDIATE CAUSE	(A) syphilitic aortitis	unknown
ANTECEDENT CAUSE (S) — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) syphilitic arteritis	unknown
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	CBS associated with CNS syphilis, meningo-encephalitic, with psychotic react.	6 months

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work [ ] Not while at work [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-15, 1955, to 3-18, 1955, that I last saw the deceased alive on 3-18, 1955, and that death occurred at 9:15AM, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeld M.D. ADDRESS Springfield State Hospital DATE SIGNED 3/18/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 3/21/55
NAME OF CEMETERY OR CREMATORY Dunkard Cem
LOCATION (City, town, or county) (State) Broadfording Md

DATE REC'D BY LOCAL REGISTRAR Mar-19, 1955
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR A K Coffman ADDRESS Hagerstown Md.

2552

02538

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 81

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Union Bridge
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Keymar
STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
PAUL	EUGENE	ROELKE	May	29	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Jan. 2-1901	54 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired.)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Grocery Dept. Camp Detrick		Maryland	U. S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Geo. W. W. Roelke	Margaret Rosenmiedel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Yes Civil Service	383-26-3631	C. M. Roelke, Keymar, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (Interval Between Onset and Death)

Immediate cause (a) Gunshot Wound of Head — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Private Porch	21c. (City or town) Union Bridge (County) Carroll (State) Md

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
3	29	55	M.		Self inflicted

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined cause ☐.

SIGNATURE James L. Marsh M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 5/30/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/2/55	Mt. Olivet Cem.	Frederick, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
	Leslie L. Eyler	D. D. Hartzler & Sons	Union Bridge, Md.

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02539

2553 CERTIFICATE OF DEATH Reg. Dist. No. 7-4

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 9/20/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
STREET ADDRESS (If rural give location) 724 Chesapeake Avenue

3. NAME OF DECEASED: (Type or Print) (First) Leilio (Middle) - (Last) ROLANDO

4. DATE OF DEATH: (Month) March (Day) 16 (Year) 19 55

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): separated

8. DATE OF BIRTH: September 1, 1888

9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR: Months - Days - IF UNDER 24 HRS: Hours - Min. -

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butler

10B. KIND OF BUSINESS OR INDUSTRY: - Nil -

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Vittorio Rolando

14. MOTHER'S MAIDEN NAME: Cesira - ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE: 422.1

(A) DUE TO: Bilateral Bronchopneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (B)

(B) DUE TO: Cerebro-vascular accident — 15 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(C) Arteriosclerotic hypertensive vascular disease — more than 3 years

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE CAUSE OR CONDITION CAUSING DEATH. Chronic Psychosis manic depressive type with hypertensive cardiovascular disease — more than 3 years

19A. DATE OF OPERATION: -

19B. MAJOR FINDINGS OF OPERATION: -

psychotic reaction

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) -

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) -

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. -

21E. INJURY OCCURRED While at work [ ] Not while at work [ ] -

21F. HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from Dec. 4, 19 54 to Mar. 16 1955, that I last saw the deceased alive on March 16, 19 55, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

SIGNATURE Florian Nadolski, M.D. M.O. ADDRESS Sykesville, Maryland DATE SIGNED 3/16/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal — DATE THEREOF 3-17-55 — NAME OF CEMETERY OR CREMATORY Mt. Olivet — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Mar. 17, 1955 — REGISTRAR'S SIGNATURE C. Tierney Ireland

24. FUNERAL DIRECTOR Wayne E. Pumphrey Inc — ADDRESS S.S. Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12540

2554

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural Sykesville — LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Liberty Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville X
STREET ADDRESS (If rural give location) Liberty Road.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Emory	Walter	Ruby	March	5	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W	Married	11-7-1873	81 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if 'retired')	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Carpenter - Civil	Springfield Hospital	Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John H. Ruby	Emily Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	-	None	Mrs Louisa Ruby Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause — (a) Arteriosclerotic cardiovascular disease with — 15+ years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (b) hypertension + myocarditis

DUE TO (c) senility

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1935, 19..., to 3-5-, 1955, that I last saw the deceased alive on 3-5-, 1955, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

J. Haworth M.D. Liberty Road at Eldersburg Sykesville 3-5-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-7-55	Mt. View	Elkridge, Howard Co., Md.

DATE RECD BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Mar. 6, 1955	C. Harry Weer	Luther H. Haight	Sykesville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12541

2555

CERTIFICATE OF DEATH

Reg. Dist. No. 7X...

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 3month12days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (24) 3Y01.4.
STREET ADDRESS (If rural give location) 12 N. Kenwood Avenue

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) (Last) SCHERPUK

4. DATE OF DEATH: (Month) March (Day) 3 (Year) 1955

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married — 8. DATE OF BIRTH: 8-6-17 — 9. AGE last birthday: 37 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wireless Operator — 10B. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander (dec'd)

14. MOTHER'S MAIDEN NAME: Sophie Bondar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-18-2361

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 421.0 — (A) Mitral valve disease — INTERVAL BETWEEN ONSET AND DEATH: Unk own

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. — DUE TO (B) Due to unknown cause

DUE TO (C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. CBS assoc. with circulatory disturbance, other than cerebral arteriosclerosis, with psychotic reaction. — months

19A. IF OPERATION: 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-12, 1954, to 3-3-, 1955, that I last saw the deceased alive on 3-2, 1955, and that death occurred at 6:45A M, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt — ADDRESS M. D. Springfield State Hospital — DATE SIGNED 3-3-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 3-5-55 — NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery — LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REGISTRAR 3-4-55 — REGISTRAR'S SIGNATURE R. W. Heidrick Dep. — 24. FUNERAL DIRECTOR ADDRESS B. Dabrowski 2818 E. Baltimore St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2556 **CERTIFICATE OF DEATH** Reg. Dist. No. 02542 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville; MARYLAND LENGTH OF STAY (in this place) since 4/6/54; HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Williamsport 21 2-A; STREET ADDRESS (If rural give location) 57 Fenton Avenue

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) William (Last) SCOTT

4. DATE OF DEATH: (Month) March (Day) 10 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: August 31, 1889

9. AGE last birthday: 65 yrs; IF UNDER 1 YEAR: Months —; Days —; IF UNDER 24 HRS: Hours —; Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Williamsport, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christian Scott

14. MOTHER'S MAIDEN NAME: Bertha Wilford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X

IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) — DUE TO

(C) —

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction. — about 5 yrs.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from May 13, 1954 to March 10 1955 that I last saw the deceased alive on March 10, 1955, and that death occurred at 8:00 pm, from the causes and on the date stated above.

SIGNATURE Florian Nadolski, M.D. ADDRESS Sykesville, Maryland DATE SIGNED 3/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: March 13/1955 — NAME OF CEMETERY OR CREMATORY: Riverview Cemetery — LOCATION (City, town, or county) (State): Williamsport, Maryland

DATE REC'D BY LOCAL REGISTRAR: Mar. 12, 1955 — REGISTRAR'S SIGNATURE: C. Harry Ward

24. FUNERAL DIRECTOR: Albert L. Leaf — ADDRESS: Williamsport, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2557 **CERTIFICATE OF DEATH** Reg. Dist. No. 774 02543

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Frederick
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville 10 x 2
STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED: (First) CHARLES (Middle) FREDERICK (Last) SHANK
4. DATE OF DEATH: (Month) MARCH (Day) 15 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
Male	White	Widowed	10-21-1869	85 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Truck Farm
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jacob Shank
14. MOTHER'S MAIDEN NAME: Angeline Eddie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE 422.1	(A) Bronchopneumonia (terminal)	4 days
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Arteriosclerotic Cardiovascular Disease	Unknown
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	CBS assoc. with circulatory disorder, with cerebral arteriosclerosis, with psychotic reaction.	4½ wks.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-11, 1955, to 3-15., 1955, that I last saw the deceased alive on 3-15, 1955, and that death occurred at 3:35 PM, from the causes and on the date stated above.

SIGNATURE Edmund Sustrans M. D. ADDRESS Springfield State Hospital DATE SIGNED 3-15-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 3-18-55
NAME OF CEMETERY OR CREMATORY Mt. Carmel and Evergreen
LOCATION (City, town, or county) Hanover Pa.
(State)

DATE REC'D BY LOCAL REGISTRAR Mch. 16, 1955
REGISTRAR'S SIGNATURE C. [illegible]
24. FUNERAL DIRECTOR C H Fuss
ADDRESS Hanover Pa.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 012544

2517 CERTIFICATE OF DEATH Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster
LENGTH OF STAY (in this place) 6yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 40 County Home

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Mt. Airy, X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) AUGUSTUS (Middle) E. (Last) SHIPLEY
4. DATE OF DEATH: (Month) March (Day) 4, (Year) 19 55
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 12- 1868
9. AGE Last birthday: 86 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: laborer
10b. KIND OF BUSINESS OR INDUSTRY: general
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John K. Shipley
14. MOTHER'S MAIDEN NAME: Rachel A. Dixon
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Albert E. Shipley, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Decompensation DUE TO — Interval Between Onset And Death: 2 yrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertension DUE TO — 7 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. X

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 1940, to 3-5, 1955, that I last saw the deceased alive on 3-5, 1955, and that death occurred at 4 PM, from the causes and on the date stated above.

SIGNATURE W. C. Hare M.D. (Degree or title) ADDRESS Westminster DATE SIGNED 3-6-55

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DATE THEREOF 3-7-1955 NAME OF CEMETERY ~~OR CREMATORY~~ Brandenburg LOCATION (City, town, or county) (State) Carroll Co. Maryland

DATE REC'D BY LOCAL REGISTRAR 3-6-55 REGISTRAR'S SIGNATURE Hamet Miller

24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Maryland

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2558

02545

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

Item 9 Primary 4-1-55 ef

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 2 y 1 m 25 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ~~Baltimore~~
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore 30, Md.
STREET ADDRESS (If rural, give location) 2704 Washington Blvd

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Robert	Merrill	Smith	3	26	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Separated	2-12-1885	69 70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
laborer	Unk.	Massachusetts	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Eugene Smith	Angie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
no	No	Unk.	Miss Eva Bean, 2704 Washington Blvd, Baltimore 30

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Lobar Pneumonia DUE TO	4 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last 902.7	(b) Fracture L rt. hip DUE TO	13 days.
	(c)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
	Hospital	Sykesville,	Carroll	Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
3 -13- 55 M.		pt. fell out of bed

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Shanok M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 3/26/55

26. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-30-55	St Peter's	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Mar. 27, 1955	C. Harry Weer	Wm Cook, Inc.	1210 E. Fayette St. Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02546

CERTIFICATE OF DEATH

2518 Reg. Dist. No. 16

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 55 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 65 Liberty St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 65 Liberty

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) CYRIL (Last) SINNOTT

4. DATE OF DEATH: (Month) 3 (Day) 27 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 19-1899

9. AGE last birthday: 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Grocery + Meat Store

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William T. Sinnott

14. MOTHER'S MAIDEN NAME: Rose Leipus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

16. SOCIAL SECURITY NO.: (If Yes, give war or dates of service) 214-01-0446

17. INFORMANT & ADDRESS: Catherine Lantz Sinnott 65 Liberty St. Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause (Final disease or condition resulting in death)	(a) Acute Coronary Thrombosis	1 hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	
	(c) DUE TO	

420.1

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/27, 1955, to 3/27, 1955, that I last saw the deceased alive on 3/27, 1955, and that death occurred at 1 P m, from the causes and on the date stated above.

SIGNATURE Thurston Bare (DEGREE OR TITLE) M.D. ADDRESS Westminster Maryland DATE SIGNED 3/28/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 3-30-1955

NAME OF CEMETERY OR CREMATORY St. John's Cemetery

LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REG. 3-29-55

REGISTRAR'S SIGNATURE Hazel Snider

24. FUNERAL DIRECTOR H. Bankard Roy ADDRESS Westminster Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

02547

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2559

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 43 yrs. 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3 W. L. 4
STREET ADDRESS (If rural give location) Unk —

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) (Last) SONNENLEITER

4. DATE OF DEATH: (Month) March (Day) 8 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 1879

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beggar

10B. KIND OF BUSINESS OR INDUSTRY: Unk —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Sonnenleiter, Sr.

14. MOTHER'S MAIDEN NAME: Unk —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk —

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

200.1 IMMEDIATE CAUSE (A) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C) Lymphosarcoma - pending Micro. investigation — Months

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenic react., paranoid type. — 43 yr. -

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-2 . . . . , 1955, to 3-8 , 1955, that I last saw the deceased alive on 3-8 , 1955., and that death occurred at 9:30PM, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeldt M. D. ADDRESS Springfield State Hosp. DATE SIGNED 3-9-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 3-11-55

NAME OF CEMETERY OR CREMATORY Cedar Hill

LOCATION (City, town, or county) (State) A. A. Co., Md.

DATE REC'D BY LOCAL REGISTRAR Mar. 9, 1955

REGISTRAR'S SIGNATURE C. Harry Zepp

24. FUNERAL DIRECTOR Charles Latimer ADDRESS 1501 E. Fort Ave. Balt.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02548

2560

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 2 yrs. 9 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda 15 X-2
STREET ADDRESS (If rural give location) 7810 Custer Road

3. NAME OF DECEASED: (Type or Print) (First) Mabel (Middle) Test (Last)

4. DATE OF DEATH: (Month) March (Day) 15 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 8-17-81
9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: ~~Hospital~~
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Hart
14. MOTHER'S MAIDEN NAME: Emily Watt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 577-16-3457
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE (A) DUE TO Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH hours

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Cerebral Arteriosclerosis — ~~hours~~ longer than 3 years

(C) Chronic ~~Brain syndrome with~~ psychotic reaction 3 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-16 , 1952, to 3-15 , 1955, that I last saw the deceased alive on 3-15 , 1955, and that death occurred at 1:25 PM, from the causes and on the date stated above.

SIGNATURE Gerbrud Sonnenfeldt M.D. ADDRESS Springfield State Hospital, Sykesville Md. DATE SIGNED 3/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 3-18-55
NAME OF CEMETERY OR CREMATORY Linwood
LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REGISTRAR June 16, 1955
REGISTRAR'S SIGNATURE C. Finley Tilden
24. FUNERAL DIRECTOR S.H. Travis - 2901 - 14th St. N.W. ADDRESS D.C.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02549

2561

CERTIFICATE OF DEATH

Reg. Dist. No. 7J

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) ANNIE (Middle) (Last) VACEK

4. DATE OF DEATH: (Month) 3 (Day) 8 (Year) 19 55

5. SEX Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: unknown

9. AGE last birthday 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bohemia

12. CITIZEN OF WHAT COUNTRY? unknown

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS. Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

9a 3.7
IMMEDIATE CAUSE (A) Multiple lung abscesses with bronchopneumonia — about 1 month

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Fracture, neck of right femur — 1 month
DUE TO (C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with cerebral arteriosclerosis. — Years

19A. DATE OF OPERATION: 2/10/55

19B. MAJOR FINDINGS OF OPERATION: Fracture, neck of femur, right; Roger-Anderson well-leg splint applied.

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.): Hospital

21C. WHERE DID INJURY OCCUR? (City or town) (County) Carroll (State) Maryland: while working in dining room at hospital

21D. TIME OF INJURY (Month) 2 (Day) 8 (Year) 55 (Hour) M.

21E. INJURY OCCURRED While at work [ ] Not while at work [X]

21F. HOW DID INJURY OCCUR? Patient fell to floor

22. I hereby certify that I attended the deceased from 2-8 ., 1955, to 3/8 ., 1955, that I last saw the deceased alive on 3/7 ., 1955 and that death occurred at 2:45A M, from the causes and on the date stated above.

SIGNATURE Walther A. Tonnesfeldt M. D. ADDRESS Springfield State Hosp. DATE SIGNED 3/8/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF Mar. 9 55 — NAME OF CEMETERY OR CREMATORY Sacred Heart Cem. — LOCATION (City, town, or county) Balto. (State) Md.

DATE REC'D BY LOCAL REGISTRAR 3/9/55 — REGISTRAR'S SIGNATURE C. M. Hedrick

24. FUNERAL DIRECTOR John L. Miller — ADDRESS 2334 Jefferson St.

2562

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02550

76

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Near Westminster
LENGTH OF STAY (in this place): 2 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 60 Westminster Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: New York — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hancock 69X-3
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) AMBROSE (Middle) DENNIS (Last) WELCOME

4. DATE OF DEATH: (Month) 3 (Day) 12 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 19, 1892

9. AGE last birthday: 63 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman for a drilling company

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Claude Welcome

14. MOTHER'S MAIDEN NAME: Angeline Demar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 188-01-7141

17. INFORMANT AND ADDRESS: Leah R. Welcome, Mexico, N.Y.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 30 min.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio sclerotic C.V. Disease with Cardiac Decompensation. — 4 wks.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1, 1955, to 3/12, 1955, that I last saw the deceased alive on 3/11, 1955, and that death occurred at 11:00 A.m., from the causes and on the date stated above.

SIGNATURE: Martin E. Strobel — (Degree or title): M.D — ADDRESS: Reisterstown, Md. — DATE SIGNED: 3/12/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Mar. 15, 1955

NAME OF CEMETERY OR CREMATORY: Dunmore Cathedral Cemetery

LOCATION (City, town, or county) (State): Scranton, Pa.

DATE REC'D BY LOCAL REG.: 3-13-55

REGISTRAR'S SIGNATURE: Mary B. Elmer / Harriett Miller

24. FUNERAL DIRECTOR / ADDRESS: J.F. Eline & Sons, Reusterstown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02551

2563

CERTIFICATE OF DEATH

Reg. Dist. No. 24

Item 8, Film 79 8-30-55 et

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 6 mos. 19 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-56-2
STREET ADDRESS (If rural give location) 11806 Dewey Road ✓

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) ESTHER (Last) WILLIAMS
4. DATE OF DEATH: (Month) 3 (Day) 23 (Year) 19 55

5. SEX: Fe Male
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 4/17/92
9. AGE last birthday 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 67

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William B. Garner
14. MOTHER'S MAIDEN NAME: Mary Martha Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk -
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

260X
IMMEDIATE CAUSE (A) Cardiac renal vascular disease — 1 year +
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis — unknown
DUE TO
(C) Diabetes mellitus — 1 year+

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain syndrome associated with circulatory disturbance, with psychotic reaction — 1 year

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/13/54, to 3/23, 19 55 that I last saw the deceased alive on 3/22, 1955, and that death occurred at 5:25AM, from the causes and on the date stated above.

SIGNATURE Walther H. Sommerfeldt M. D. ADDRESS Sykesville, Maryland DATE SIGNED 3/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial + Removal
DATE THEREOF 3-24-55
NAME OF CEMETERY OR CREMATORY Geo. Wash. Cem -
LOCATION (City, town, or county) (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Mar. 24, 1955
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Deal Funeral Hom
ADDRESS 4815 Mass Ave Wash NW

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.